

SUMMARY REPORT: RATES AND ACCOUNTABILITY HSC TECHNICAL ASSISTANCE WORK GROUP – 3/21/11

A workgroup of human service advocates and providers has examined how to reshape human service funding in Illinois to adequately cover provider cost, incentivize the most efficient service delivery models, increase care coordination, measure performance outcomes and hold providers accountable for meeting outcome measures. The workgroup included experts in the following areas: mental health, substance abuse, domestic violence, developmental disabilities, child care, and home- and community-based services for older adults. The purpose of the workgroup's final report is to provide an overview of the current conditions and trends surrounding provider compensation and how, and whether, the current system incentivizes various types of service provision and outcomes. The workgroup developed a set of recommendations for moving toward an outcomes-based reimbursement system.

The State of the Current System

1. As with the majority of public services provided in Illinois, the State itself does not provide many human services directly. Rather, the state contracts with private and non-profit providers, as well as local governments, to deliver the services on a contract basis.
2. Nearly all human service providers are paid on a fee-for-service (FFS) basis. This reimbursement structure more often than not incentivizes providers to deliver as many services as they can and does not encourage care management and coordination. In most cases, and except where care coordination is specifically contracted, care coordination is simply not reimbursed or incentivized. Accordingly, the current fee structure fosters neither short-term nor long-term individualized care planning or service efficiencies.
3. In fields where state FFS rates were set years ago, they bear little relation to the actual cost of providing the service.
4. Accordingly, rates paid are significantly lower than the cost of providing the service, leaving providers to subsidize the true cost of services by raising additional funds from non-governmental sources such as individual donors, corporations and foundations.
5. In some fields, rates for programs are not differentiated to reflect the variation in costs presented by the level of client need and risk factors. For instance, services for the most significantly impaired disabled individuals are often reimbursed at the same amount for programs delivering care to those with far fewer cognitive or physical challenges.
6. The state generally reimburses providers for only a narrowly defined set of services that focus more on meeting immediate rather than longer-term needs. Because only a limited set of services is reimbursable, there is little opportunity for service innovation.

7. In most cases, the state does not pay for case management services that would facilitate greater coordination of care across providers and the reduction in the duplication of services. For instance, the state requires many domestic violence programs to coordinate care for clients but provides no funding for it. The state cannot expect providers to deliver services in excess of what they are paid to do, particularly when the reimbursement for the contracted service does not even cover that cost. Despite the lack of reimbursement for case management, the state is putting tremendous pressure on providers to do more of it.
8. On many contracts, the current FFS system does not provide sufficient reimbursement for essential operational expenses such as administration, capital investment or program evaluation. These costs are legitimate provider costs that should be taken into account for any reimbursement structure.
9. In many fields, the state does not pay for case management services that would facilitate greater coordination of care across providers. In some fields, like domestic violence, the state requires care coordination for clients but provides no funding for it.
10. Because reimbursement rates are below actual provider cost, providers are unable to offer competitive wages and benefits to their employees. In turn, providers and their clients experience high degrees of employee turnover, which imposes costs on the agencies and reduces the quality of client services provided. In some settings, this results in the ability to pay only lower-skilled workers. Even for the dedicated individuals who are drawn to these positions despite the low compensation, career opportunities are limited because of the low pay.
11. The current FFS system does not utilize provider quality or performance measures sufficiently across all services. In some cases where quality incentives do exist, such as in QRS ratings in child care, they are implemented ineffectively.
12. Illinois has a higher rate of institutionalization than most state for individuals suffering from mental illness, developmentally disabilities, or the effects of aging. It is far more costly to care for individuals in a large institutional setting than in a small group home or in their own home with the support of home and community based services. In addition to cost implications, the Americans with Disabilities Act and other civil rights legislation also mandates the integration of persons with developmental disabilities and mental illness with their communities in the “least restrictive setting.” In addition, the recent Illinois Medicaid Reform legislation calls for the rebalancing of long-term care with an increased emphasis on the use of home and community based services. Similarly, the Money Follows the Person Initiative, of which Illinois is taking part, also promotes transition back to the community in lieu of long term residential placement.

Trends and Implications of the current system

1. Illinois faces an unprecedented budget crisis that has been developing for over a decade. Human services have received a disproportionate amount of funding cuts over the last several years. Cumulatively, the imperative to reduce direct state expenditures for services has affected providers in many fields through the loss or reduction of service contracts, rationing of services of many types in many areas, long-frozen reimbursement rates and payment delays. Rising provider costs, largely outside their control, such as for medical benefits and cost-of living increases, has meant that over this period many providers have faced a rate decrease year after year in real terms.
2. As Medicaid has become an increasingly large funding source for Illinois social services, its rules and rates have increasingly defined how much providers are paid and for what. In theory, this could have increased the total resources available to human services, enabling providers to increase their array of services to the Medicaid-eligible population while still providing some services to the non-Medicaid-eligible. However, the State often diverted these increased federal resources to areas outside human services. Thus, despite the influx of 'new' funding to human services, the sector did not see increased funding for quality and service improvements, or the preservation of funding for some Medicaid-ineligible persons.
3. If implemented well, the ACA provisions for health information exchanges could facilitate greater coordination of care and compensate providers for "meaningful use" of new systems.
4. The State has begun a Medicaid pilot program for integrated, managed care. A major goal of the program is better coordinated care, which has the potential to reduce overall program costs. While the pilot has the potential to improve access to preventative care and needed specialty services, there is also concern that costs will simply be reduced through restricted access to services without significant benefit to clients. In addition, managed care approaches may encourage greater care coordination and incent more holistic outcomes, but they also place more financial risk on the provider with respect to clients with less predictable service needs. The human services industry should carefully monitor the Medicaid Integrated Care pilot for what works, and what does not, in terms of the appropriate balance between care coordination and the proper utilization of services.
5. Across aging, developmental disabilities and mental health, there is a movement toward serving more people either in their homes or other community settings, rather than in larger institutions. In order for this movement to be successful in Illinois, the payment system will need to incentivize providers to create the needed service settings.
6. With the new state-level budgeting for outcomes, there will be increased pressure on state agencies and, therefore, their contracted providers, to measure and be accountable for outcomes of their work in order to continue to receive financial support

for their programs. At this time, only the broadest outline of how the new system might operate has been created.

Recommendations

How, exactly, payment and accountability systems would best operate varies across different service fields. Recommendations unique to each area may be found in the individual service area sections of this report. General principles for payment and accountability that tend to be common to fields are as follows:

1. Providers across all of the human services domains must be paid for the full cost of the services they provide, including the specific service contracted for, care coordination, administrative and capital costs.
2. Reimbursement rates should be reviewed at least annually by an independent third party to determine how they will be updated to reflect actual costs.
3. Systems and incentives that support and invest in coordination of care should be developed and expanded. Better-coordinated care holds promise for reducing overall governmental care expenditures as it reduces duplication of service and has greater potential for clients to successfully access multiple care systems to meet their needs.
4. Payment systems should incentivize services provided in less costly community-based settings rather than larger institutional and urgent care settings. Rate systems should be embedded in a framework that meaningfully supports client choice. Rebalancing service between large institutional and community-based care would be facilitated by stronger payments to community care providers that have the effect of incentivizing them to develop greater capacity. This includes the ability to provide better compensation to their workers, thereby improving quality and reducing turnover, which benefits all consumers.
5. Systems and incentives that support coordination of care should be developed and expanded. If done well, better-coordinated care holds promise for reducing overall governmental expenditures if clients that access multiple care systems become more independent and use fewer or no services.
6. Payment systems should incorporate performance and outcomes measures including broad, long term outcomes, and program-specific outcomes.
7. Contracting should be performance-based and must incent quality and efficiency. Depending on the setting, this could include
 - a. Tying contract renewal to performance
 - b. Tying full contract payment to performance
 - c. Providing bonuses when high performance measures are achieved

d. Competitive bidding

As a general principle, systems where “money follows the person” are the preferred mechanism for allocating state payments to providers. The chief advantages of following this method are a) consumers are able to exercise choice in which providers or services to utilize and b) the method incentivizes providers to deliver quality in order to retain market share.

8. The service system needs to set goals for client outcomes for which providers are accountable and that align with outcomes for which state agencies are held accountable.
9. Outcomes need to be developed through a process that includes the recommendations of elected officials, state agencies, service providers, subject matter experts, and consumers.
10. Outcomes may be defined in a number of ways. At the highest level they may include items such as maximizing the number of children prepared to learn, ensuring human capital sufficient to make the state economically strong, or reducing crime. Other outcomes may be narrower, such as maintaining a high quality of life for a severely disabled person or reducing the likelihood of recidivism for a re-entering offender. Outcomes will need to be consistent with state and federal mandates.
11. Payment mechanisms need to be appropriate for two types of client services:
 - A) Basic care-taking wherein a service is provided but change in intrinsic health or ability on the part of the client is not the foremost consideration. These would include, in some instances, home assistance to seniors or services for the disabled, where the underlying condition of the consumer may make it extremely difficult or impossible to achieve certain markedly discernable changes in status. Specific quality benchmarks can and should be developed in these instances that rely on other discernable hallmarks, such as recognized best practices in care-giving.
 - a. B) Services where a successful outcome requires behavioral change or accomplishment of an outcome by the client. These might include job searches, prisoner re-entry services, mental health treatment or substance abuse treatment. In these instances, a client outcome, rather than the act of providing the service, is the goal. In some instances, maintenance of baseline functioning must be recognized as a positive outcome, e.g. no emergency room visits.
12. Where possible, outcomes should be defined so as to reduce the volume of state services that need to be provided. This might be accomplished by

a) Achievement of efficiency in the service delivery system

b) Better service coordination such that client problems are solved more holistically, thereby reducing the likelihood of the need for services in the future

c) Systems that result in the elimination of providers who deliver poor quality services, consistently fail to meet objective standards, or are cost-inefficient.

13. Provider payments need to be sufficient to cover costs but need to be tied to accomplishment of outcomes. In some instances, those outcomes may be substantially within the control of the service provider. In other instances, achievement of the outcome may require quality service provision by multiple providers. In the latter instance, payment incentive mechanisms must be developed that incent providers to work together, but that reward quality provided by individual service providers. In all cases, consumer characteristics and service mix must be taken into consideration for provider compensation such that clients requiring more complex or more volume of services are compensated for those costs.